Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ADL Services

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-14-2013-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 7, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After exhausting our efforts with Texas Mutual Insurance Company, our agency is required an appeal for the attached billing cycle due to being denied."

Amount in Dispute: $1,320.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed for services of a home health aide on a CMS-1500 from. Medicare requires such billing to be on a UB-04. For this reason Texas Mutual declined to issue payment."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 16 – 30, 2013	G0156	$1,320.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.202 sets out the fee guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 892 – All home health service must be billed on a UB04 with each DOS listed separately
   - 193 – Original payment decision is being maintained

Issues

1. Did the requestor submit claim in compliance with Division rules?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed services as 892 – "All home health service must be billed on a UB04 with each DOS listed separately." 28 Texas Labor Code §134.202 (b) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section." Review of the Centers for Medicare and Medicaid Services (CMS), Claims Processing Manual, Chapter 10, states in pertinent part, "40 - Completion of Form CMS-1450 for Home Health Agency Billing (Rev. 3021, Issued: 08-08-14, Effective: 01-01-12, Implementation: 09-08-14) The Social Security Act at §1862 (a)(22) requires that all claims for Medicare payment must be submitted in an electronic form specified by the Secretary of Health and Human Services, unless an exception described at §1862 (h) applies. The electronic form required for billing home health services is the ASC X12 837 institutional claim transaction. Since the data structure of the 837 transaction is difficult to express in narrative form and to provide assistance to small providers excepted from the electronic claim requirement, the instructions below are given relative to the data element names on the Form CMS-1450 hardcopy form.

   Based on the above, the Division finds the Carrier's denial is supported.
2. Requirements of Rule 134.202 (b) were not met. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		February 26, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.